Individualized Health Care Plan

Allergies

Student Name ___________________________ D.O.B. ____________ Grade ________
Classroom ____________________ Allergic To __________________

*For children with multiple allergies, use one form for each allergy

♦ History of Allergic Reactions ♦ How many reactions: ________ Date of last reaction: _________

Asthma □ Yes □ No  *Children with Asthma are at high risk for severe reaction
Inhaler at School □ Yes □ No
Medical I.D. Worn □ Yes □ No

♦ Signs of Allergic Reaction ♦ NOTE: The severity of symptoms can quickly change.

Systems Symptoms
- MOUTH Itching & swelling of the lips, tongue, or mouth
- SKIN Hives, itchy rash, and/or swelling about the face or extremities
- GUT Nausea, abdominal cramps, vomiting, and/or diarrhea
- THROAT* Itching and/or a sense of tightness in throat, hoarseness, and hacking cough
- LUNG * Shortness of breath, repetitive coughing, and/or wheezing
- HEART* Thready pulse, passing-out, pale, blueness
- Other _______________________________________________________________________

* Potentially Life Threatening

♦ Action for Minor Reaction ♦

1. If only symptom(s) are: ____________________________________________, give ________________________________, medication/dose/route

Then call:

2. Mother__________________________, Father ____________________________, or emergency contacts.
3. Dr. _____________________________ at ____________________________

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

♦ Action for Major Reaction ♦

1. If ingestion is suspected and/or symptom(s) are: ____________________________________________________________, immediately!

Then call:

2. 911! Do not hesitate. Ask for advanced life support. State that an allergic reaction has been treated and additional epinephrine may be needed.

3. Mother__________________________, Father ____________________________, or emergency contacts.
4. Dr. _____________________________ at ____________________________ Medical # __________________________
∗ Emergency Contacts ∗

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<tr>
<th>Name</th>
<th>Relationship</th>
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EPIPen® AND EPIPen® JR. DIRECTIONS

1. Pull off gray activation cap.

![EPIDN®](image)

2. Hold black tip near outer thigh (always apply to thigh).

3. Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen® unit should then be removed and taken with you to the Emergency Room. Massage the injection area for 10 seconds.

Parent’s Signature ___________________________ Date_______________

Physician’s Signature ___________________________ Date_______________

∗ For children with multiple allergies, use one form for each allergy. ∗